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IN THE
Supreme Court of the United States

RICHARD ARMSTRONG AND LISA HETTINGER,
Petitioners,

v.

EXCEPTIONAL CHILD CENTER, INC.; INCLUSION, INC.; TOMORROW'S HOPE SATELLITE SERVICES, INC.; WDB, INC.; AND LIVING INDEPENDENTLY FOR EVERYONE, INC.,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

BRIEF FOR THE AMERICAN HOSPITAL ASSOCIATION AND THE FEDERATION OF AMERICAN HOSPITALS AS AMICI CURIAE IN SUPPORT OF RESPONDENTS

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STATEMENT OF INTEREST[1]

The American Hospital Association and the Federation of American Hospitals respectfully submit this brief as *amici curiae*.

[1] No party or counsel for a party authored this brief in whole or in part. No party, counsel for a party, or person other than the *amici curiae*, their members, or counsel made a monetary contribution intended to fund the preparation of submission of this brief. All parties have filed blanket amicus consent letters.

The American Hospital Association (AHA) represents nearly 5,000 hospitals, health systems, and other health care organizations, along with 43,000 individual members. AHA members are committed to improving the health of the communities they serve, and to helping ensure that care is available to, and affordable for, all Americans. As part of its mission, the AHA educates its members on health care issues and advocates to ensure that their perspectives are considered in formulating health policy.

The Federation of American Hospitals is the national representative of investor-owned or managed community hospitals and health systems throughout the United States. Dedicated to a market-based philosophy, the FAH provides representation and advocacy on behalf of its members to Congress, the Executive Branch, the judiciary, media, academia, accrediting organizations and the public.

AHA and FAH members play a vital role in ensuring access to health services for the nearly 65 million Americans covered by Medicaid. That program is today the Nation's single most important health care safety net. It covers more Americans than Medicare or any private insurer. And it is a critical source of funding for the hospitals and health care systems that serve the country's most vulnerable populations.

This case concerns the right of healthcare providers, including AHA and FAH members, to challenge state regulations preempted by the substantive provisions of the Medicaid Act. Because such suits are crucial to preserving access to the level of care Congress intended Medicaid to provide, *amici* respectfully urge this Court to affirm the judgment below.

SUMMARY OF ARGUMENT

A. Congress enacted Medicaid as a cooperative federal–state program to provide medical care for the neediest Americans. To realize the program's objectives, Congress placed conditions on participating states. One such condition, set out in Section 30(A) of the Medicaid Act, requires states to reimburse healthcare providers at rates sufficient to ensure that Medicaid beneficiaries enjoy the same access to health care as the general population.

Section 30(A)'s promise of equal access is central to Medicaid's purpose—yet states have repeatedly cut reimbursement rates to levels far below providers' actual costs, without taking into account how that harms providers or constrains the availability of health care for the neediest Americans. In 2012, the cost of providing care to Medicaid beneficiaries exceeded reimbursements by *$13.7 billion*, up from $11.3 billion in 2009. This persistent gap threatens the availability of quality medical care for tens of millions of people. After all, providers can only endure for so long if they suffer a loss with each patient they treat.

Without recourse to the courts to enforce the conditions Congress set in place, hospitals and other providers will continue to bear losses that, for some, are unsustainable.

B. Reimbursement rates set without regard to the availability or cost of care violate Section 30(A). Like any other state regulation in conflict with federal law, they are subject to preemption under the Supremacy Clause.

For over a hundred years, this Court has recognized that sovereign immunity does not extend to

state officials enforcing state laws in derogation of federal authority. *Ex parte Young*, 209 U.S. 123, 159 (1908). In that time, this Court has decided dozens of cases seeking injunctive and declaratory relief from state regulations on preemption grounds.

Provider suits challenging state Medicaid reimbursement rates fit squarely into this mold. They advance congressional intent by enforcing the conditions Congress imposed on state participation, without asserting any private entitlement. And because courts must defer to permissible agency determinations of compliance with the Medicaid Act, provider suits pose no obstacle to the cooperative process set in place by the statute. The decision below should be affirmed.

ARGUMENT

I. Section 30(A) Imposes Important Substantive Limitations On States' Authority To Set Reimbursement Rates.

1. Medicaid is a critical source of health coverage nationwide. The program provides care to 64.9 million Americans—one-fifth of the population. U.S. Dep't of Health & Human Svcs., *2014 CMS Statistics*, tbl. I.16.[2] Along with its companion program, CHIP, Medicaid covers more than one in three of the nation's children. Robin Rudowitz, *et al.*, *Children's Health Coverage: Medicaid, CHIP and the ACA*, Kaiser Comm'n on Medicaid and the Uninsured,

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[2] *Available at* http://goo.gl/7qL19Z. Proportion based on U.S. Census Bureau population estimates, *available at* http://goo.gl/fldA45.

Mar. 2014.[3] In 2010, Medicaid paid for the health care costs associated with 48 percent of all births in the United States. Anne Rossier Markus, *et al.*, *Medicaid Covered Births, 2008 Through 2010, in the Context of Implementation of Health Reform*, 23 Women's Health Iss. e273, e276 (2013).[4] And the program is all the more important during economic downturns, when enrollments surge. *See* Katherine Young, *et al.*, *Medicaid Spending Growth in the Great Recession and its Aftermath, FY 2007-2012*, Kaiser Comm'n on Medicaid and the Uninsured (July 2014).[5]

Every State participates in Medicaid, and each State has an agency that administers the program. Providers who treat Medicaid beneficiaries are reimbursed directly by state administrators. States recoup a fixed percentage of those costs in matching funds from the federal government. 42 U.S.C. § 1396b; 79 Fed. Reg. 3387 (Dec. 13, 2013). Federal matching funds and related incentives account for an average of 59.1 percent of state Medicaid spending. Pew Charitable Trusts & MacArthur Found., *State Health Care Spending on Medicaid*, 2 (July 2014).[6] That makes Medicaid the largest source of federal revenue flowing to the States. *See* Nat'l Ass'n of State Budget Officers, *State Expenditure Report* 11 (Nov. 2014).[7]

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[3] *Available at* http://goo.gl/W7cBg4.

[4] *Available at* http://goo.gl/rEZJfl.

[5] *Available at* http://goo.gl/Vi2XAo.

[6] *Available at* http://goo.gl/4hePOF.

[7] *Available at* http://goo.gl/TYL6Bf.

2. To qualify for federal matching funds, States must prepare a "plan for medical assistance" that conforms to certain statutory criteria. The plan and any subsequent amendments must be approved by the Centers for Medicare & Medicaid Services (CMS), the agency that oversees the program. 42 U.S.C. § 1316(a). Although States enjoy broad flexibility in designing a Medicaid plan, that flexibility has limits. *See Alexander* v. *Choate*, 469 U.S. 287, 303 (1985) (noting States' discretion to define coverage "as long as" plan conforms to the statute's substantive requirements).

Among other things, Section 30(A) of the Medicaid Act requires that every State plan

> provide such methods and procedures relating to the utilization of, and the payment for, care and services * * * as may be necessary * * * *to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population* in the geographic area[.]

42 U.S.C. § 1396a(a)(30)(A) (emphasis added). The applicable regulations clarify that Section 30(A) requires that a state "agency's payments * * * be sufficient to enlist enough providers * * * ." 42 C.F.R. § 447.204.

Congress added Section 30(A) to the Medicaid Act in 1989. The provision codified an existing regulation that was "rarely enforced," leaving hospitals and other providers with "wholly inadequate reimburse-

ments." 135 Cong. Rec. S1643, S1661 (Feb. 23, 1989) (Stmt. of Sen. Biden); see Pub. L. 101-239, § 6402(a).

3. In spite of Congress' express intent to ensure adequate reimbursement, states have continued to slash Medicaid reimbursement rates or hold them at artificially low levels. Indeed, many states reimburse providers so little for treating Medicaid patients that the providers suffer a substantial loss with every single Medicaid patient they treat. The consequence is exactly what Congress wanted to avoid: Providers' ability to provide high quality care—and in some cases their financial viability—are jeopardized, and so in turn is the availability of quality healthcare for many millions of Americans.

a. In 2012, the most recent year for which data are available, American hospitals treated 11.2 million Medicaid beneficiaries. *See 2014 CMS Statistics*, *supra*, at table IV.1. For every dollar they spent on those patients, hospitals were reimbursed just 89 cents. American Hosp. Ass'n, *Trendwatch Chartbook 2014*, tbl. 4.4.[8] That figure amounts to an overall payment shortfall of $13.7 billion, up from $11.3 billion in 2009. *See id.*, tbl. 4.5. And it comes on top of $45.9 billion of uncompensated medical care hospitals provided to patients that year alone, up from $39.1 billion in 2009.

Although CMS is authorized to withhold federal funding from states that fail to comply with their approved plans, 42 U.S.C. § 1396c, that disciplinary mechanism has not stemmed the trend of below-cost reimbursement rates. In 2012, the year this Court

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[8] *Available at* http://goo.gl/3Lsttf.

last considered the issue presented here, thirteen states cut Medicaid spending to balance their budgets. Matthew Fleming and Phil Galewitz, *13 States Cut Medicaid to Balance Budgets*, Kaiser Health News, July 24, 2012.[9] Five of those states rolled back reimbursements to hospitals, ranging from a $150 million reduction in California to a 5.6 percent cut in Florida. *See id.*

Nor was that a one-year aberration. In 2013, another five states cut back rates for outpatient hospital care and thirty-eight states cut reimbursements for inpatient care. Kaiser Fam. Found. & Nat'l Ass'n of Med. Dirs., *Medicaid in an Era of Health & Delivery System Reform* 34-36 (Oct. 2014).[10] And in 2014, seven states cut back outpatient reimbursements and thirty states cut back inpatient reimbursements. *Id.*

States also contribute to providers' financial instability by failing to account for the ever-increasing costs of providing medical care. To take just one particularly egregious example: Pennsylvania last updated its outpatient reimbursement rates in *1991*, *see* Steve Twedt, *Medicaid Reimbursement Woes Persist*, Pittsb'g Post Gaz., Oct 21, 2013[11]—a 23-year period during which the average cost of medical care has more than doubled, *see Forecast Chart, US Medical Cost Inflation*.[12]

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[9] *Available at* http://goo.gl/JT1lNN.

[10] *Available at* http://goo.gl/jP3Mcq.

[11] *Available at* http://goo.gl/oYkyWT.

[12] *Available at* http://goo.gl/TSfgrc. Nor is Pennsylvania alone. Connecticut has refused to adjust hospital rates for inflation

b. These data underscore a basic, and brutal, truth: States are balancing their budgets on the backs of the providers that care for the neediest Americans. That is dangerous not just to providers but to patients—the focus of Congress', and hospitals', concern. In many cases, the hospitals that treat the largest proportion of Medicaid beneficiaries are the very hospitals that can least afford to take a loss, patient after patient. That puts beneficiaries' access to medical care at risk.

Nationwide, nearly 26 percent of hospitals endure negative operating margins. *See Trendwatch Chartbook 2014*, *supra*, at tbl. 4.1. The hospitals that treat the most Medicaid patients also tend to face the most significant financial challenges. In 2012, hospitals in the top quartile for the number of Medicaid patients they treated had operating margins 18 percent lower than their peer hospitals.[13] And these are the very hospitals that are being persistently underpaid by the states: From 2000 to 2012, state cuts to Medicaid reimbursement left hospitals treating Medicaid patients with nearly $100 billion in shortfalls. *See id.* at tbl. 4.5. These shortfalls force hospitals to

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since 2002. *See* Letter from CMS Director Cindy Mann to Commissioner Roderick L. Bremby, Conn. Dep't of Soc. Svcs. (Mar. 18, 2014). And in Arizona, the State cut hospital payment rates by 5 percent in 2011 and froze rates through 2013. It projected that the changes would more than double the number of hospitals taking in *only 50-60 cents for each dollar they spend* to provide care. Milliman, Inc., *Arizona Medicaid Access to Hospital Care—2013 Evaluation* 3 (June 2012), *available at* http://goo.gl/aQGwsq.

[13] Analysis of AHA Annual Survey Data.

forego capital investments, maintenance, and improvements to services. And in some cases they jeopardize providers' ability to continue treating patients at all.

Providers' preemption challenges to state plans that violate Section 30(A) are therefore critical to preserving the integrity of the Medicaid system and the availability of quality, affordable health care for all Americans.

II. The Supremacy Clause Provides A Cause Of Action To Enjoin State Violations Of Section 30(A).

Providers should be able to continue bringing these important lawsuits. This Court has long recognized the power of federal courts to hear cases, like this one, that "seek injunctive relief from state regulation, on the ground that [it] is pre-empted by a federal statute which, by virtue of the Supremacy Clause of the Constitution, must prevail." *Shaw* v. *Delta Airlines, Inc.*, 463 U.S. 85, 96 n.14 (1983). Indeed, as the United States concedes, this Court has decided "dozens" of preemption claims on the merits without requiring an express or implied statutory cause of action. *See* U.S. Br. 16 (collecting cases). Such claims "give[ ] life to the Supremacy Clause." *Green* v. *Mansour*, 474 U.S. 64, 68 (1985). There is no reason to change course now.

A. Preemption Suits Enforce The Federal Order, Not Individual Rights.

Petitioners frame this case as an effort by Respondents to vindicate a private right. It is not. The supremacy of federal law, like the separation of powers, is a bedrock of our constitutional order; it

would make little sense to cast enforcement of either principle in terms of private rights. *See INS* v. *Chadha*, 462 U.S. 919 (1983); *Golden State Transit* v. *City of Los Angeles*, 493 U.S. 103, 117 (1989) (Kennedy, J., dissenting) ("Pre-emption concerns the federal structure of the Nation rather than the securing of rights, privileges and immunities to individuals."). *Cf. Chapman* v. *Houston Welfare Rights Org.*, 441 U.S. 600, 615 (1979) (distinguishing between suits brought to vindicate rights "secured by the Constitution" and suits alleging "incompatibility between federal and state statutes and regulations" under the Supremacy Clause).

1. The central question in preemption challenges is whether Congress intended to displace inconsistent state regulation. *See, e.g., Rowe* v. *New Hampshire Motor Transp. Ass'n*, 552 U.S. 364, 370-373 (2008); *Pacific Gas & Elec. Co.* v. *State Energy Res. Conserv. & Dev. Comm'n*, 461 U.S. 190, 203-204 (1983); *Ray* v. *Atlantic Richfield*, 435 U.S. 151, 157-158 (1978). Contrary to Petitioners' view, that analysis has never depended on whether the state regulation at issue affects the plaintiff's "primary conduct" or whether the suit amounts to an "anticipatory defense" to an enforcement action. *See* Pet. Br. 40-44. Rather, it is "essentially a two-step process of first ascertaining the construction of the two statutes and then determining the constitutional question of whether they are in conflict." *Perez* v. *Campbell*, 402 U.S. 637, 644 (1971).

The plaintiffs in this case alleged, and the courts below found, just such a conflict between Idaho's

outdated reimbursement rates and Section 30(A).[14] Under this Court's precedent, that conflict rendered the rate regulations invalid. *See, e.g.*, *Arkansas Dep't of Health & Human Svcs.* v. *Ahlborn*, 547 U.S. 268, 272 (2006) (invalidating state attachment provision as inconsistent with the Medicaid Act); *Carleson* v. *Remillard*, 406 U.S. 598, 604 (1972) (invalidating state criteria for benefits eligibility at variance from federal standard); *Townsend* v. *Shank*, 404 U.S. 282, 285 (1971) (same); *King* v. *Smith*, 392 U.S. 309, 333 (1968) (same). And because "[t]he state has no power to impart to [an official] any immunity from responsibility to the supreme authority of the United States," the district court properly enjoined their enforcement. *Ex parte Young*, 209 U.S. at 159.

2. This Court's consistent focus on the compatibility between state and federal law explains why affirming Medicaid providers' rights to bring suit under the Supremacy Clause would not "effect a complete end-run around this Court's implied right of action and 42 U.S.C. § 1983 jurisprudence." Pet. Br. 19 (quoting *Douglas* v. *Indep. Living Ctr. of S. Cal., Inc.*, 132 S. Ct. 1204, 1213 (2012) (Roberts, C.J., dissenting)).

First, whether a state regulation frustrates some congressional purpose is a question distinct from whether Congress intended to allow suits for damages or other individualized relief. *Cf. Nat'l Pvt. Truck Council, Inc.* v. *Oklahoma Tax Comm'n*, 515 U.S. 582, 592 (1995) (Kennedy, J., concurring) (distin-

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[14] Because this Court declined to grant review on the merits, *see* 135 S. Ct. 44 (2014) (Mem.), Petitioners have not challenged that conclusion here.

guishing between suits asserting a federal statute's preemptive force and those asserting private rights). Second, even if the inquiries overlapped, that would not render the implied-right-of-action jurisprudence a dead letter because plaintiffs can bring suits under the Supremacy Clause only when they seek equitable relief from *state law* or actions that have the force of law. Plaintiffs seeking to vindicate federal rights as against private defendants, rather than to preempt contrary state law or regulation, would still have to show that Congress provided them with a right of action. The same goes for plaintiffs bringing run-of-the-mine constitutional tort claims for damages against individuals acting under color of law.

The obvious difference between invalidating a law or regulation as preempted and vindicating a private right also vitiates Petitioners' claim that cases like *Maine* v. *Thiboutot*, 448 U.S. 1 (1980), and *Astra USA, Inc.* v. *Santa Clara Cnty., Calif.*, 131 S. Ct. 1342 (2011), foreclose Respondents' suit. *See* Pet. Br. 24-27. In both cases, this Court observed that a party could sue to obtain some benefit under a statute only if Congress had intended to provide a private right of action. But pure preemption challenges are not demands for particular rates or other benefits; they do no more than enforce the "federal structure of the Nation." *Golden State Transit*, 493 U.S. at 117 (Kennedy, J., dissenting).

B. Petitioners' Attempts To Recharacterize This Court's Preemption Cases Are Unpersuasive.

Preemption claims, in short, do not vindicate—and therefore do not require—an individual right. That is why, as the United States is forced to concede, this

Court has decided "dozens" of preemption claims on the merits without identifying an express or implied statutory cause of action. U.S. Br. 16.

Petitioners and their *amici* proffer a grab bag of explanations to differentiate this mountain of adverse precedent from the case at hand. They say the Court allows affirmative preemption claims only when the plaintiff can "assert an independent federal right that is impaired by state regulation," Pet. Br. 43, or when the plaintiff faces a "burden" because of state law, U.S. Br. 32, or when the state law regulates the plaintiff's "primary conduct," U.S. Br. 31. None of these descriptions successfully distinguishes the past cases from this one.

1. Petitioners argue that this Court has allowed affirmative preemption claims only when the plaintiff can "assert an independent federal right that is impaired by state regulation." Pet. Br. 43. That argument defeats itself. It defines the concept of a "right" so broadly that, if accepted, it would only prove that *the Respondent providers here*, too, have an "independent federal right."

For nearly fifty years, this Court has recognized that preemption claims do not implicate individual rights secured by the constitution. *Swift & Co.* v. *Wickham*, 382 U.S. 111, 120 (1965); *accord Chapman*, 441 U.S. at 615. In other words, the "right" to be free from preempted state regulation is just a rhetorical consequence of "the Supremacy Clause's separate protection of the federal structure from the division of power in the constitutional system." *Golden State Transit*, 493 U.S. at 118 (Kennedy, J., dissenting). Whether Congress intended to displace state law has nothing to do with whether Congress

has conferred "private rights to an[] identifiable class." *Gonzaga Univ.* v. *Doe*, 536 U.S. 273, 283-284 (2002) (internal quotation marks omitted); *cf. Dennis* v. *Higgins*, 498 U.S. at 439, 462-463 (1991) (Kennedy, J., concurring) (the "ability to invoke the Commerce Clause against a State * * * is not equivalent to finding a secured right under § 1983").

To say that this Court's preemption cases have relied on federal "rights" makes sense only if that word is defined so loosely as to include an entitlement to be free from state law that conflicts with federal law. And if that definition holds true, then Respondents here must also have a federal right: the right to be free from state Medicaid regulations that violate Section 30(A).

2. The United States concedes that several of this Court's recent preemption cases did not involve anything that could be considered a "right" for Section 1983 or implied-right-of-action purposes. U.S. Br. 16-17 & n.6. Having parted with Petitioners on this point, the United States tries to distinguish the cases on the grounds that they "involved claims for relief from *state-law requirements or other burdens* that were allegedly inconsistent with federal law." U.S. Br. 32 (emphasis added). But again, that is no distinction at all. Respondents contend that the State's regulations burden them by setting Medicaid reimbursement rates in a manner that fails to account for the cost and availability of care. The United States' characterization sweeps in this case.

Perhaps recognizing as much, the United States next urges that preemption claims lie only where the state-law requirements burden the plaintiffs' "primary conduct." *Id.* at 31; 18-19. But that limitation is

plucked from thin air. The "primary conduct" limitation is nowhere to be found in this Court's opinions, and the United States does not attempt to argue otherwise.

In sum, Petitioners and their *amici* cannot wish away this Court's preemption cases. The doctrinally significant attribute these cases share is that they challenged state regulation on the grounds that it was preempted by federal law. *See, e.g.*, *Perez*, 402 U.S. at 644; *Rowe*, 552 U.S. at 370-373; *Pacific Gas & Elec. Co.*, 461 U.S. at 203-204; *Atlantic Richfield*, 435 U.S. at 157-158. Respondents should be allowed to do the same here.

C. Medicaid Preemption Claims Further Congress's Expressed Intent.

Petitioners insist that, even if the Supremacy Clause authorizes preemption claims in some cases, it does not authorize claims that state law is preempted by Section 30(A). Not so. "[A]ny state legislation which frustrates the full effectiveness of federal law is rendered invalid by the Supremacy Clause," *Perez*, 402 U.S. at 652, and state law that conflicts with Section 30(A) is no different.

1. Petitioners argue that Section 30(A) preemption suits are barred under this Court's Spending Clause jurisprudence because they impermissibly "impose[ ] on [S]tates requirements they did not bargain for." Pet. Br. 31. They do no such thing. This is not a case where, for example, a state is being asked to pay for some benefit not specifically identified in the Spending Clause statute at issue. *E.g., Arlington Cent. Sch. Dist. Bd. of Educ.* v. *Murphy*, 548 U.S. 291 (2006). Quite the contrary: Section 30(A) explicitly tells states the criteria they must meet when they set

reimbursement rates. Private suits do no more than hold states to the terms of their agreement.

2. Petitioners and their *amici* also contend that judicial scrutiny of states' compliance with Section 30(A) disrupts federal-state cooperation, inhibits states' ability to plan their Medicaid expenditures, and lacks administrable standards. Those objections are misguided.

a. Medicaid preemption suits do not interfere with CMS's ability to exercise its discretion in reviewing and approving state Medicaid plans and amendments. As a practical matter, states that make lawful changes to their reimbursement rates will normally enjoy a decisive advantage in preemption litigation because courts must defer to CMS's reasonable determinations. *E.g.*, *Douglas* v. *Independent Living Ctr. of So. Cal., Inc.*, 132 S. Ct. 1204, 1210-11 (2012); *see Chevron, U.S.A., Inc.* v. *Natural Res. Def. Council, Inc.*, 467 U.S. 837, 842-843 (1984). Where a State violates the statute or the terms of an approved plan and CMS fails to act, or where CMS makes a determination that is not entitled to deference, a ruling that a state plan or amendment violates Section 30(A) is entirely consistent with the statutory scheme.

While no one doubts that CMS is "comparatively expert in the statute's subject matter," *Douglas*, 132 S. Ct. at 1210, CMS has no more authority to ignore Congress' intent—whether by approving an amendment that flouts Section 30(A) or by staying on the sidelines—than a state does. That is why courts owe deference only to "permissible constructions" of an ambiguous statute and, "[i]f the intent of Congress is clear, that is the end of the matter; for the court, as

well as the agency, must give effect to the unambiguously expressed intent of Congress." *Chevron*, 467 U.S. at 842-843. However delicate the balance states may wish to strike with CMS, they must respect the bounds that Congress set.

The United States advances the related argument that preemption suits would complicate CMS's oversight role by leading to development of divergent standards in courts across the country. U.S. Br. 24-25. That is equally unpersuasive. CMS itself has "considered and declined to propose setting a single uniform Federal standard for reviewing substantive compliance with [Section 30(A)'s] access requirements because [it] believe[s] that determination of such compliance is very fact-specific and data-specific, taking into consideration local circumstances." 76 Fed. Reg. 26342, 26349 (May 6, 2011); *see* U.S. Br. 13-14 & n.5. So the possibility that the circuits will develop different standards for assessing compliance with Section 30(A) does not itself frustrate any CMS policy of nationwide uniformity. And to the extent CMS interprets some portion of the statute in a manner that requires uniformity, that interpretation will control where it is entitled to deference.

b. California claims, as *amicus*, that preemption suits destabilize states' ability to plan and budget. It argues that its "inability to predict how courts * * * would misinterpret § 30(A) has cost its Medicaid program" an average of 0.27 percent of its Medicaid budget per year since 2008. Calif. Br. 10-11, 14. But its supposedly illustrative examples offer no support for its argument.

First, California complains that CMS delayed and then declined to give full retroactive effect to its approval of the plan amendments challenged in *Douglas*.[15] *Id.* at 10-11. But that grievance is better addressed to CMS than to the *Douglas* plaintiffs.[16] Even if CMS's decision was based on the concern that preemption-related injunctions had caused providers to accumulate so much in over-reimbursements that recoupment risked "harm [to] providers and beneficiaries," *id.* at 11, its determination was an exercise of agency discretion.

California's second example is no more persuasive. The state argues that it suffered losses in a case where a district court enjoined an amendment after refusing to give deference to CMS's approval. The injunction was vacated on appeal, but California avers that it was forced to divert resources to meet the pre-amendment reimbursement rates in the interim. *See Managed Pharmacy Care* v. *Sebelius*, 716 F.3d 1235 (9th Cir. 2013) *cert. denied*, 134 S. Ct. 900 (2014) and *cert. denied sub nom. California Med. Ass'n* v. *Sebelius*, 134 S. Ct. 986 (2014).

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[15] CMS regulations provide that an amendment affecting a State's "payment methods and standards" may "become effective not earlier than the first day of the calendar quarter in which an approvable amendment is submitted." 42 C.F.R. § 447.256.

[16] Or perhaps to California itself: The State appears to have been at least partially to blame for the delay, refusing to provide CMS with information concerning the impact of the proposed amendments on beneficiary access when it originally submitted them for approval, then failing to respond to CMS's specific follow-up requests for that information for nearly two years. *See* U.S. Br. 2a-3a, *Douglas*, 132 S. Ct. 1204 (2012).

What California does not—and cannot—explain is how foreclosing preemption suits would prevent such a disruption in the future. Any aggrieved party may always challenge a final determination by CMS under the Administrative Procedure Act, just as the plaintiffs did in the very case California cites. *See id.* at 1240. The risk that a district court will enjoin an amendment approved by CMS and be reversed on appeal is not eliminated by foreclosing preemption suits.

c. Finally, Petitioners argue that Section 30(A) is not amenable to enforcement because it "does not obligate the State to do *anything*." Pet. Br. 52 (emphasis in original). Not so. Section 30(A) unambiguously requires States that participate in Medicaid to set their reimbursement rates according to certain criteria. If the Act does not mandate particular rates, it nevertheless bars States from enacting regulations that purport to set Medicaid reimbursement levels in a manner inconsistent with those criteria.[17] *Perez*, 402 U.S. at 652 (Supremacy Clause invalidates any regulation that "frustrates the full effectiveness of federal law"). Respondents' objection is relevant—if at all—only to the nature of the relief a court may grant. But there can be no question that courts may enjoin the implementation of rate plans developed without regard to the statutory factors, or

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[17] Respondents' analogy to the national minimum drinking age provision, 23 U.S.C. § 158, makes little sense. Pet. Br. 51. State alcohol regulations do not purport to regulate the nation's highways. By contrast, a state's Medicaid reimbursement rates dictate how providers who participate in Medicaid will be paid. That is precisely the field Congress regulated with Section 30(A).

require state officials to bring existing plans in line with federal law by undertaking "such methods and procedures" as the Act requires.

CONCLUSION

The long-established ability to challenge state law under the Supremacy Clause is crucial to ensuring that States respect their Medicaid Act commitments to the neediest Americans. The judgment of the court of appeals should be affirmed.

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